

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12309
CERTIFICATE OF DEATH

12306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Sykesville				c. LENGTH OF STAY IN 1b 52yrs. 4mos. 28das. Baltimore City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Abbis		4. DATE OF DEATH Month 11 Day 5 Year 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months --- Days --- Hours --- Min. ---	IF UNDER 24 HRS. Months --- Days --- Hours --- Min. ---	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cooper		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? unknown	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Christina -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records - Springfield State Hospt. Sykesville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left myocardial infarction DUE TO coronary ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) --- DUE TO --- (c) ---						INTERVAL BETWEEN ONSET AND DEATH months years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19 58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from August , 19 55 , to Nov. 5 , 19 58 , that I last saw the deceased alive on November 4 , 19 58 , and that death occurred at 8:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED ---							
ACTUAL SIGNATURE Walter Knopp				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-7-58		22c. NAME OF CEMETERY OR CREMATORY WESTERN		22d. LOCATION (City, town, or county) (State) BALTIMORE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE (Name and address) Geo. F. Schupp, 2101 Frederick Ave				24a. REC'D BY REGISTRAR NOV 7 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Knapp	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1872</u></p>	
<p>5. Place of birth: <u>City, State</u></p>		<p>6. Date of death: <u>Dec 10, 1917</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Signature of informant: <u>John Doe</u></p>		<p>12. Signature of witness: <u>John Doe</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12310

CERTIFICATE OF DEATH

Reg. Dist. No.

12307

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland b. COUNTY City 311			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 14 months 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4			
d. STREET ADDRESS 824 W. 32nd St., Baltimore 11, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First William		Middle George		Last Albright	
4. DATE OF DEATH		Month 11-		Day 22		Year - 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-81		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Belt Machinist		10b. KIND OF BUSINESS OR INDUSTRY Continental Can		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cyrus Albright				14. MOTHER'S MAIDEN NAME Philathea Fishpaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-09-8394		17. INFORMANT Hospital records. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease, with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year 11-22-58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11-22-58 , 19 58 , to 11-22-58 , 19 58 , that I last saw the deceased alive on 11-22-58 , 19 58 , and that death occurred at 11.00P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Agustin del Campo</i>		M.D. Springfield State Hospital		ADDRESS (Street, city or town, state) Sykesville, Maryland.		DATE SIGNED 11-23-58	
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 26, 1958	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burgee Funeral Home</i>				ADDRESS 3631 Falls Road		24a. REC'D BY REGISTRAR DATE NOV 25 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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10. *Journal of the American Medical Association*, 1990; 263: 1033-1037.

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References

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12311

CERTIFICATE OF DEATH

Reg. Dist. No. 12308

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>	
c. LENGTH OF STAY IN 1b <u>9 days</u>		d. STREET ADDRESS <u>North Main</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>North Main</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Elizabeth</u> Last <u>Allsip</u>		4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1876</u>
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Bloomer</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Sleas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Sara Allsip (Daughter) -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Pernicious Anemia</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 12, 1958</u> , to <u>Nov 15, 1958</u> , that I last saw the deceased alive on <u>Nov. 12, 1958</u> , and that death occurred at <u>12:05 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>Mount Airy, Md.</u> DATE SIGNED <u>Nov 15, 1958</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 17, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Mem. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Indiana, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin J. Molesworth</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 18 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1921

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH April 15, 1921		6. PLACE OF DEATH Home	
7. TIME OF DEATH 10:30 AM		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Coronary Artery Disease		10. PREVIOUS ILLNESS None	
11. OCCUPATION Retired		12. MARITAL STATUS Married	
13. PLACE OF BIRTH Maryland		14. DATE OF BIRTH March 1, 1856	
15. SIGNATURE OF DECEASED (None)		16. SIGNATURE OF WITNESSES (None)	
17. SIGNATURE OF PHYSICIAN (None)		18. SIGNATURE OF CORONER (None)	
19. SIGNATURE OF REGISTRAR (None)		20. SIGNATURE OF CLERK (None)	

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12312

12309

Reg. Dist. No.

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12312

CERTIFICATE OF DEATH

12309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>JULIA - F - ARMACOST</u>				4. DATE OF DEATH <u>Nov 28 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 21 - 1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>David Riceman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Mrs. Maurice Smith - Greenmount Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>332X</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Viral respiratory infection (1st two weeks November)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>November 1st 1958</u> to <u>November 28 1958</u> , that I last saw the deceased alive on <u>November 28 1958</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. C. Porterfield</u>				ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>			
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>				DATE SIGNED <u>11/29/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Dec 1/58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Tipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12313

CERTIFICATE OF DEATH

12310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore County 03			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1mth. 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Granite 03X-2			
f. STREET ADDRESS Summit Ave.				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Forrest Middle Eugene Last Ayer				4. DATE OF DEATH Month 11 Day 22 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-83	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY BLdg. Const.		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel B. Ayer				14. MOTHER'S MAIDEN NAME Anza Thorn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. 235-20-8392.		17. INFORMANT Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, without qualifying phrase—Bronchopneumonia. 491X				INTERVAL BETWEEN ONSET AND DEATH years years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-17- 1958 to 11-22- 1958 that I last saw the deceased alive on 11-22- 1958 and that death occurred at 3.55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 11-22-58							
ACTUAL SIGNATURE Agustin del Campo M.D.							
PHYSICIAN'S NAME (Type) Agustin del Campo M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-26-58		22c. NAME OF CEMETERY OR CREMATORY WESTLEY Chapel		22d. LOCATION (City, town, or county) (State) Knottsville W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Geo. L. Schwab ADDRESS Barbara M. Schwab 2101 Medicine Cove				24a. REC'D BY REGISTRAR NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12345

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John Doe		Male		45		12-15-1900		New York City	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
123 Main St.		Teacher		Heart Disease		Natural		New York City	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
12-20-1945		10:30 AM		10		30		00	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
New York City		12-20-1945		10:30 AM		10		30	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
12-20-1945		10:30 AM		10		30		00	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
New York City		12-20-1945		10:30 AM		10		30	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
12-20-1945		10:30 AM		10		30		00	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
New York City		12-20-1945		10:30 AM		10		30	

12314

CERTIFICATE OF DEATH

12311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2mos. 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (Also known as Franklin E. Bartholow) Frank Edwin Bartholow		4. DATE OF DEATH Month November Day 5 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1885
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall B. Bartholow		14. MOTHER'S MAIDEN NAME Alice Stoner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction plus C.B.S. with convulsive disorder. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 2, 1958 to November 5, 1958 , that I last saw the deceased alive on November 5, 1958 , and that death occurred at 10:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 11/6/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 10, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR NOV 10 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12315 **CERTIFICATE OF DEATH**

12312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD C. BIXLER</u>				4. DATE OF DEATH Month Day Year <u>NOV. 5 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 1 - 1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER-TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COLLEGE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>URIAH BIXLER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH MYERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS RUTH BARNETT, NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral softening</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1952</u> to <u>11-5-58</u> , that I last saw the deceased alive on <u>Nov 3, 1958</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Reese Wilkens</u>				DATE SIGNED <u>15 Kem PER Westminster</u>			
PHYSICIAN'S NAME (Type) <u>DR. REESE WILKENS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIED</u>		22b. DATE THEREOF <u>11/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Reese Wilkens</u>				24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Registrar	
11. Signature of Physician		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of Health Officer		15. Signature of Town or City Clerk	
16. Signature of Burial Officer		17. Signature of Undertaker		18. Signature of Funeral Home		19. Signature of Cemetery		20. Signature of Interment	
21. Signature of Burial		22. Signature of Burial		23. Signature of Burial		24. Signature of Burial		25. Signature of Burial	
26. Signature of Burial		27. Signature of Burial		28. Signature of Burial		29. Signature of Burial		30. Signature of Burial	
31. Signature of Burial		32. Signature of Burial		33. Signature of Burial		34. Signature of Burial		35. Signature of Burial	
36. Signature of Burial		37. Signature of Burial		38. Signature of Burial		39. Signature of Burial		40. Signature of Burial	
41. Signature of Burial		42. Signature of Burial		43. Signature of Burial		44. Signature of Burial		45. Signature of Burial	
46. Signature of Burial		47. Signature of Burial		48. Signature of Burial		49. Signature of Burial		50. Signature of Burial	
51. Signature of Burial		52. Signature of Burial		53. Signature of Burial		54. Signature of Burial		55. Signature of Burial	
56. Signature of Burial		57. Signature of Burial		58. Signature of Burial		59. Signature of Burial		60. Signature of Burial	
61. Signature of Burial		62. Signature of Burial		63. Signature of Burial		64. Signature of Burial		65. Signature of Burial	
66. Signature of Burial		67. Signature of Burial		68. Signature of Burial		69. Signature of Burial		70. Signature of Burial	
71. Signature of Burial		72. Signature of Burial		73. Signature of Burial		74. Signature of Burial		75. Signature of Burial	
76. Signature of Burial		77. Signature of Burial		78. Signature of Burial		79. Signature of Burial		80. Signature of Burial	
81. Signature of Burial		82. Signature of Burial		83. Signature of Burial		84. Signature of Burial		85. Signature of Burial	
86. Signature of Burial		87. Signature of Burial		88. Signature of Burial		89. Signature of Burial		90. Signature of Burial	
91. Signature of Burial		92. Signature of Burial		93. Signature of Burial		94. Signature of Burial		95. Signature of Burial	
96. Signature of Burial		97. Signature of Burial		98. Signature of Burial		99. Signature of Burial		100. Signature of Burial	

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12316 CERTIFICATE OF DEATH

12313

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg Rural				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jesse Middle Albertus Last Bostian				4. DATE OF DEATH Month November Day 28 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1879		9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) elevator operator				10b. KIND OF BUSINESS OR INDUSTRY Feed Mill		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Jacob Bostian				14. MOTHER'S MAIDEN NAME Sarah Eyler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-10-9805		17. INFORMANT Mrs. Jesse A. Bostian, Middleburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov 28, 1958 , to Nov 28, 1958 , that I last saw the deceased alive on Nov 28, 1958 , and that death occurred at 2:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Union Bridge Rd DATE SIGNED 11-29-58 ACTUAL SIGNATURE T. H. Legg M.D. Union Bridge Rd PHYSICIAN'S NAME (Type) T. H. LEGG M.D. Union Bridge Rd							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF December 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Haugh's Cemetery		22d. LOCATION (City, town, or county) (State) Ladiesburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss				ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR DEC 3 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CERTIFICATE OF DEATH

Control

Registration

Medical

Funeral

Age

Sex

Color

Religion

Marital

Birth

Death

Place

Time

Cause

Place of Burial

Signature

Registrar

Medical Officer

Funeral Director

Witness

Place of Burial

Time

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Carrall</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Carrall</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Winstunster</i>	c. LENGTH OF STAY IN 1b <i>3 1/2 yrs -</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Winstunster</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Home 7</i>		1d. STREET ADDRESS <i>R7 Box 160 A</i>	
3. NAME OF DECEASED (Type or print) First <i>ELSIE</i> Middle <i>VIRGINIA</i> Last <i>BROOKS</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 13, 1884</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William H. Burall</i>		14. MOTHER'S MAIDEN NAME <i>Laura M. Haines</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>	
17. INFORMANT <i>Maurice C. Brooks R7 Winstunster Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Ca of lung</i> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ca of Breast</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr -</i> <i>years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 12</i> , 1958 to <i>Nov 13</i> , 1958, that I last saw the deceased alive on <i>Nov 13</i> , 1958, and that death occurred at <i>4:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James J. Marsh</i>		ADDRESS (Street, city or town, state) <i>105 E MAIN St. Winstunster Md</i>	
PHYSICIAN'S NAME (Type) <i>JAMES T. MARSH</i>		DATE SIGNED <i>11/13/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/17/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jim. J. Sickner</i>		24a. REC'D BY REGISTRAR <i>NOV 17 '58</i>	
ADDRESS <i>Sous-Balto Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12304

CERTIFICATE OF DEATH

12315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 E. Green St.				d. STREET ADDRESS 1 119 E. Green St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Minerva Middle Agnes Last Burner				4. DATE OF DEATH Month November Day 28 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 22, 1871	
				9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Charles W. Merryman				14. MOTHER'S MAIDEN NAME Irena Purkey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mrs. Eunice Buckingham Westminster, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis & Bronchitis Sensitized yes (c) Arterio Sclerosis (Genl) 5 yrs							INTERVAL BETWEEN ONSET AND DEATH 10-15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 19, 1957 , to November 28, 1958 , that I last saw the deceased alive on Nov 28, 1958 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Glenn Speicher				ADDRESS (Street, city or town, state) Westminster, Md.			
DATE SIGNED 11/29/58							
PHYSICIAN'S NAME (Type) W. Glenn Speicher 135 E. Main St. Westminster, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 1, 1958		22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR DEC 2 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12318 **CERTIFICATE OF DEATH** **12316**

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Baltimore City 311			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 5mths, 23 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6 3V01-4				d. STREET ADDRESS 5417 Belle Vista Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Bessie Middle Margaret Last Caldwell		4. DATE OF DEATH		Month 11 Day 21 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1896	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Housewife) Waitress		10b. KIND OF BUSINESS OR INDUSTRY F.W. Woolworth		11. BIRTHPLACE (State or foreign country) Maryland (Baltimore)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Griggs				14. MOTHER'S MAIDEN NAME Margaret Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-16-4563		17. INFORMANT Hospital records. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO 416 x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Rheumatic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH days year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Mental Deficiency						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-28- 1958 , to 11-21- 1958 , that I last saw the deceased alive on 11-21- 1958 , and that death occurred at 9.00 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11-22-58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-25-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE NOV 25 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED [Name]		SEX [Male/Female]		RACE [Race]		DATE OF BIRTH [Date]		PLACE OF BIRTH [Place]	
RESIDENCE [Address]		OCCUPATION [Occupation]		CAUSE OF DEATH [Cause]		DATE OF DEATH [Date]		PLACE OF DEATH [Place]	
MANNER OF DEATH [Manner]		MEDICAL HISTORY [History]		PREVIOUS ILLNESS [Illness]		PREVIOUS SURGERY [Surgery]		PREVIOUS TRAUMA [Trauma]	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF WITNESS [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12319

CERTIFICATE OF DEATH

12317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN - WILLIAM - CAPE</u>		4. DATE OF DEATH <u>Nov 22 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14 - 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cape</u>		14. MOTHER'S MAIDEN NAME <u>Susan Wink</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-1204</u>	
17. INFORMANT <u>Addie Shilke - upper MD</u>		Address <u>upper MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO <u>Hypertension</u> (c) <u>✓</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN</u> <u>5 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1956</u> to <u>Nov 22 1958</u> , that I last saw the deceased alive on <u>April 1958</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foward</u>		DATE SIGNED <u>11-24-58</u>	
PHYSICIAN'S NAME (Type) <u>W H Foward M.D.</u>		<u>Manchester, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Church</u>		22d. LOCATION (City, town, or county) (State) <u>Manchester, Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw & Tipton, Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Nov 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH	
JAMES EARL RAY		MALE		39		WHITE		JAN 5, 1928	
6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
MEMPHIS, TENN.		MEMPHIS, TENN.		APR 4, 1968		10:00 AM		HEART DISEASE	
11. FULL NAME OF PHYSICIAN		12. FULL NAME OF ATTENDING NURSE		13. FULL NAME OF REGISTRAR		14. FULL NAME OF CLERK		15. FULL NAME OF WITNESS	
DR. J. H. HARRIS		MISS M. J. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS		MR. J. H. HARRIS	
16. FULL NAME OF FUNERAL HOME		17. FULL NAME OF BURIAL PLACE		18. FULL NAME OF CEMETERY		19. FULL NAME OF CHURCH		20. FULL NAME OF MINISTERS	
JAMES EARL RAY FUNERAL HOME		JAMES EARL RAY FUNERAL HOME		JAMES EARL RAY FUNERAL HOME		JAMES EARL RAY FUNERAL HOME		JAMES EARL RAY FUNERAL HOME	
21. FULL NAME OF CORONER		22. FULL NAME OF JURY		23. FULL NAME OF JUDGE		24. FULL NAME OF CLERK		25. FULL NAME OF WITNESS	
JAMES EARL RAY CORONER		JAMES EARL RAY JURY		JAMES EARL RAY JUDGE		JAMES EARL RAY CLERK		JAMES EARL RAY WITNESS	
26. FULL NAME OF STATE ATTORNEY		27. FULL NAME OF DISTRICT ATTORNEY		28. FULL NAME OF COUNTY ATTORNEY		29. FULL NAME OF CITY ATTORNEY		30. FULL NAME OF TOWNSHIP ATTORNEY	
JAMES EARL RAY STATE ATTORNEY		JAMES EARL RAY DISTRICT ATTORNEY		JAMES EARL RAY COUNTY ATTORNEY		JAMES EARL RAY CITY ATTORNEY		JAMES EARL RAY TOWNSHIP ATTORNEY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 12320 CERTIFICATE OF DEATH

12318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 5 mos. 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Austin Last Casey		4. DATE OF DEATH Month November Day 14 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel erector		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Casey		14. MOTHER'S MAIDEN NAME Martha McIntire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-09-4149	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction due to arterio-sclerotic coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with alcohol intoxication without qualifying phrase.			INTERVAL BETWEEN ONSET AND DEATH Hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 29, 19 58 to November 14, 19 58 , that I last saw the deceased alive on November 14, 19 58 , and that death occurred at 7:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Irene L. Hitchman M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/15/58	
PHYSICIAN'S NAME (Type) Irene L. Hitchman, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF Nov. 19, 58	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Belair Road Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR NOV 18 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form 10-1-1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1920		New York City		New York City		Heart Disease		Jan 15, 1965		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.	
Occupation		Marital Status		Previous Illnesses		Date of Last Examination		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice		Date of Last Medical Advice	
Teacher		Married		None		Jan 1, 1960		Jan 1, 1960		Jan 1, 1960		Jan 1, 1960		Jan 1, 1960		Jan 1, 1960		Jan 1, 1960		Jan 1, 1960		Jan 1, 1960	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Jan 15, 1965		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1965		10:00 AM		New York City		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1965		10:00 AM	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12321

CERTIFICATE OF DEATH

12319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hydenville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Hydenville</i>	
c. LENGTH OF STAY IN 1b <i>Life</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hydenville</i>	
3. NAME OF DECEASED (Type or print) First <i>David</i> Middle <i>Constantine</i> Last <i>Constantine</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>30</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 17, 1900</i>
9. AGE (In years last birthday) <i>58</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Male Nurse</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Constantine</i>		14. MOTHER'S MAIDEN NAME <i>Chusan Shryfogle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>215-09-0904</i>	
17. INFORMANT <i>Mrs Helen Constantine - Hydenville, Md.</i>		Address <i>Hydenville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of colon, generalized</i> 152.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>new diabetes, Arteriosclerosis, interstitial</i> DUE TO (c) <i>obstruction, multiple fistula</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1955 to 30 Nov 1958</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1955</i> , 19 <i>Nov</i> , to <i>Nov</i> , 1958, that I last saw the deceased alive on <i>30 Nov</i> , 1958, and that death occurred at <i>7:24 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E. Hall</i> M.D.		ADDRESS (Street, city or town, state) <i>Hydenville, Md</i> DATE SIGNED <i>30 Nov 58</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		<i>Hydenville, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>12-3-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Memorial</i>	22d. LOCATION (City, town, or county) (State) <i>Hydenville, Carroll Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Haight</i>		ADDRESS <i>Hydenville, Md.</i>	
24a. REC'D BY REGISTRAR <i>DEC 2 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Haight</i>	

OF MASSACHUSETTS
THE OFFICIAL
STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH

WALTON-BRIDG

1921

MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON
CERTIFICATE OF DEATH

10

Case No.

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

OCCUPATION

PREVIOUS ILLNESS

DIAGNOSIS

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF REGISTRAR

SIGNATURE OF REGISTRAR

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF WITNESS

SIGNATURE OF WITNESS

DATE OF SIGNATURE

PLACE OF SIGNATURE

12322

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>Walnut Ave. - Edinburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>H.</u> Last <u>COOK</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1874</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Cook</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT Address <u>Mrs Annie Cook - Sykesville, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage into bowel</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of stomach</u> DUE TO <u>gastric ulcer</u> (c) <u>gastric ulcer</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>6 mo.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>bilateral lobar pneumonia 490 x</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN</u> 19 <u>57</u> to <u>NOV</u> 19 <u>58</u> , that I last saw the deceased alive on <u>19</u> 19 <u>58</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. V. Houck Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>LIBERTY RD. SYKESVILLE, MD.</u>			
DATE SIGNED <u>11-22-58</u>							
PHYSICIAN'S NAME (Type) <u>R. V. HOUCK Jr</u>				ADDRESS <u>LIBERTY RD. SYKESVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Berraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Bldg. md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, md.</u>				24a. REC'D BY REGISTRAR <u>NOV 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Haight</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1882

File No. 10

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of death</p>	
<p>5. Place of birth</p>		<p>6. Usual residence</p>		<p>7. Cause of death</p>		<p>8. Manner of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>		<p>11. Signature of witness</p>		<p>12. Signature of family</p>	
<p>13. Signature of health officer</p>		<p>14. Signature of coroner</p>		<p>15. Signature of jury</p>		<p>16. Signature of jury</p>	
<p>17. Signature of jury</p>		<p>18. Signature of jury</p>		<p>19. Signature of jury</p>		<p>20. Signature of jury</p>	
<p>21. Signature of jury</p>		<p>22. Signature of jury</p>		<p>23. Signature of jury</p>		<p>24. Signature of jury</p>	
<p>25. Signature of jury</p>		<p>26. Signature of jury</p>		<p>27. Signature of jury</p>		<p>28. Signature of jury</p>	
<p>29. Signature of jury</p>		<p>30. Signature of jury</p>		<p>31. Signature of jury</p>		<p>32. Signature of jury</p>	
<p>33. Signature of jury</p>		<p>34. Signature of jury</p>		<p>35. Signature of jury</p>		<p>36. Signature of jury</p>	
<p>37. Signature of jury</p>		<p>38. Signature of jury</p>		<p>39. Signature of jury</p>		<p>40. Signature of jury</p>	
<p>41. Signature of jury</p>		<p>42. Signature of jury</p>		<p>43. Signature of jury</p>		<p>44. Signature of jury</p>	
<p>45. Signature of jury</p>		<p>46. Signature of jury</p>		<p>47. Signature of jury</p>		<p>48. Signature of jury</p>	
<p>49. Signature of jury</p>		<p>50. Signature of jury</p>		<p>51. Signature of jury</p>		<p>52. Signature of jury</p>	
<p>53. Signature of jury</p>		<p>54. Signature of jury</p>		<p>55. Signature of jury</p>		<p>56. Signature of jury</p>	
<p>57. Signature of jury</p>		<p>58. Signature of jury</p>		<p>59. Signature of jury</p>		<p>60. Signature of jury</p>	
<p>61. Signature of jury</p>		<p>62. Signature of jury</p>		<p>63. Signature of jury</p>		<p>64. Signature of jury</p>	
<p>65. Signature of jury</p>		<p>66. Signature of jury</p>		<p>67. Signature of jury</p>		<p>68. Signature of jury</p>	
<p>69. Signature of jury</p>		<p>70. Signature of jury</p>		<p>71. Signature of jury</p>		<p>72. Signature of jury</p>	
<p>73. Signature of jury</p>		<p>74. Signature of jury</p>		<p>75. Signature of jury</p>		<p>76. Signature of jury</p>	
<p>77. Signature of jury</p>		<p>78. Signature of jury</p>		<p>79. Signature of jury</p>		<p>80. Signature of jury</p>	
<p>81. Signature of jury</p>		<p>82. Signature of jury</p>		<p>83. Signature of jury</p>		<p>84. Signature of jury</p>	
<p>85. Signature of jury</p>		<p>86. Signature of jury</p>		<p>87. Signature of jury</p>		<p>88. Signature of jury</p>	
<p>89. Signature of jury</p>		<p>90. Signature of jury</p>		<p>91. Signature of jury</p>		<p>92. Signature of jury</p>	
<p>93. Signature of jury</p>		<p>94. Signature of jury</p>		<p>95. Signature of jury</p>		<p>96. Signature of jury</p>	
<p>97. Signature of jury</p>		<p>98. Signature of jury</p>		<p>99. Signature of jury</p>		<p>100. Signature of jury</p>	

1882

1882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12323 CERTIFICATE OF DEATH

12321

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		c. LENGTH OF STAY IN 1b 5 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster		d. STREET ADDRESS Route Sullivan Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 3 Sullivan Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Alonzo Last Crumbie		4. DATE OF DEATH Month Nov. Day 9 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Crumbie		14. MOTHER'S MAIDEN NAME Kid Orr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-05-3139	
17. INFORMANT Charles Crumbie R. 3 Westminster, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Anteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.0 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/11 , 19 58 , to Nov 9 , 19 58 , that I last saw the deceased alive on Nov 5 , 19 58 , and that death occurred at 6 A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE W H Foard M.D. Manchester, Md		11-10-58	
PHYSICIAN'S NAME (Type) W. H. Foard M.D.		Manchester, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-13-58	
22c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		22d. LOCATION (City, town, or county) (State) Westminster, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR DATE NOV 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

STATE OF NEW YORK

1933

<p>1. Name of deceased: <u>John J. Smith</u></p>		<p>2. Date of death: <u>Jan 15 1933</u></p>	
<p>3. Place of death: <u>Home</u></p>		<p>4. Age: <u>65</u> years</p>	
<p>5. Sex: <u>Male</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Marital status: <u>Married</u></p>		<p>8. Occupation: <u>Teacher</u></p>	
<p>9. Cause of death: <u>Heart disease</u></p>		<p>10. Immediate cause: <u>Myocardial infarction</u></p>	
<p>11. Contributing causes: <u>None</u></p>		<p>12. Duration of illness: <u>2 weeks</u></p>	
<p>13. Name of attending physician: <u>Dr. J. H. Jones</u></p>		<p>14. Name of medical examiner: <u>Dr. A. B. Brown</u></p>	
<p>15. Name of funeral home: <u>None</u></p>		<p>16. Name of cemetery: <u>None</u></p>	
<p>17. Name of next of kin: <u>John J. Smith</u></p>		<p>18. Name of informant: <u>John J. Smith</u></p>	
<p>19. Name of registrar: <u>John J. Smith</u></p>		<p>20. Name of official: <u>John J. Smith</u></p>	

12324

CERTIFICATE OF DEATH

12322

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 17yrs. 1mo. 4days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 603 Greene St.	
3. NAME OF DECEASED (Type or print) First Kathleen Middle Veronica Last DAVIS		4. DATE OF DEATH Month November Day 12, Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Davis		14. MOTHER'S MAIDEN NAME Mary Cordial	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung abscess with empyema, right lung 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.			INTERVAL BETWEEN ONSET AND DEATH Weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 7, 1955 to November 12, 1958 that I last saw the deceased alive on November 11, 1958 and that death occurred at 12:01 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/12/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/58	22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE NOV 17 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12345

CERTIFICATE OF DEATH

12345

NAME OF DECEASED John Doe		AGE 45	SEX Male	RACE White	DATE OF BIRTH 1900-01-01
PLACE OF BIRTH Baltimore, Maryland		CITY Baltimore	COUNTY Baltimore	STATE Maryland	COUNTRY United States
OCCUPATION Teacher		EDUCATION High School	RELIGION Roman Catholic	MARRIAGE Married	
DATE OF DEATH 1945-03-15		TIME OF DEATH 10:00 AM	PLACE OF DEATH Home	CAUSE OF DEATH Heart Disease	
DISEASE OR INJURY Myocardial Infarction		PERIOD OF ILLNESS 2 weeks	PREVIOUS ILLNESS None	TREATMENT Medical	
SIGNATURE OF PHYSICIAN Dr. J. K. Smith		DATE 1945-03-16	SIGNATURE OF WITNESSES John Doe, Sr. and Mary Doe		
SIGNATURE OF REGISTRAR John Doe		DATE 1945-03-16	SIGNATURE OF CLERK Mary Doe		

12325

CERTIFICATE OF DEATH

12323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 6 1/2 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore. 18, 3001.4	
f. STREET ADDRESS 15151 Fernley Rd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lydia Mary Etzweiler Dockstader		4. DATE OF DEATH Month November Day 1 Year 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/04
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR Months 6 Days 15 Hours Min. 	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Etzweiler		14. MOTHER'S MAIDEN NAME Polly Ritzman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Elizabeth Conrad Chew		Address 1515 Fernley Rd. Baltimore 18, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with Cerebral Arteriosclerosis with Psychotic Reactions		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/22/58 , 19 , to 11/1/58 , 19 , that I last saw the deceased alive on 11/1/58 , 19 , and that death occurred at 11:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Augustin Del Campo M.D. PHYSICIAN'S NAME (Type) Augustin Del Campo, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/58	22c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cem	22d. LOCATION (City, town, or county) (State) Preverton Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc. 5305 Harford Rd.		24a. REC'D BY REGISTRAR DATE NOV 5 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Huns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12326

CERTIFICATE OF DEATH

12324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>J.</u> Last <u>DURHAM</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Evans McDowell</u>		14. MOTHER'S MAIDEN NAME <u>Ellen (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Elizabeth D. Anderson-R.F.D. #3 Sykesville</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrotic (chronic) Cystitis (chr)</u> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disturbance</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June, 1958</u> , to <u>Nov. 16, 1958</u> , that I last saw the deceased alive on <u>11-15-58</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm C. Jernette</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>103 E Main Annapolis 11-16-58</u>	
PHYSICIAN'S NAME (Type) <u>Wm C. Jernette</u>		<u>105 E Main Westminister Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, and completely filled out by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		Maryland		Baltimore		Heart Disease		Jan 15, 1938		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar	
Occupation		Marital Status		Previous Illnesses		Last Medical Examination		Manner of Death		Burial or Disposition		Funeral Home		Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Teacher		Married		Hypertension		Dec 1, 1937		Natural		Catholic		St. Mary's		Catholic		Jan 16, 1938		11:00 AM		Catholic		Jan 16, 1938	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Undertaker		Signature of Burial Place		Signature of Burial Date		Signature of Burial Time		Signature of Burial Place		Signature of Burial Date		Signature of Burial Time	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JAN 16 1938
BALTIMORE, MARYLAND
STATE DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12327

CERTIFICATE OF DEATH

12325

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 21 yr. 5m. 19d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS Baltimore City			
3. NAME OF DECEASED (Type or print) First CHRIST Middle GEORGE Last GEORGE				4. DATE OF DEATH Month November Day 30 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 64 ?		IF UNDER 1 YEAR Months ? Days ? Hours ? Min. ?		IF UNDER 24 HRS. Months ? Days ? Hours ? Min. ?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Greece	
12. CITIZEN OF WHAT COUNTRY? ?				13. FATHER'S NAME ?			
14. MOTHER'S MAIDEN NAME ?				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. -----				17. INFORMANT Records, Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Schizophrenic reaction, paranoid type				INTERVAL BETWEEN ONSET AND DEATH Minutes Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 5:55		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to November 30, 1958 , that I last saw the deceased alive on November 30, 1958 , and that death occurred at 5:55 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.				DATE SIGNED Springfield State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Newell		ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DEC 5 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Huns	

CERTIFICATE OF DEATH

1935

The Day of

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p> <p>19. SIGNATURE OF NEXT OF KIN</p> <p>20. SIGNATURE OF BURIAL OFFICIAL</p> <p>21. SIGNATURE OF FUNERAL HOME</p> <p>22. SIGNATURE OF CEMETERY</p> <p>23. SIGNATURE OF INTERVIEWER</p> <p>24. SIGNATURE OF SUPERVISOR</p> <p>25. SIGNATURE OF CLERK</p> <p>26. SIGNATURE OF ASSISTANT CLERK</p> <p>27. SIGNATURE OF RECEPTIONIST</p> <p>28. SIGNATURE OF MAIL ROOM</p> <p>29. SIGNATURE OF TELEPHONE ROOM</p> <p>30. SIGNATURE OF JANITOR</p> <p>31. SIGNATURE OF NIGHT WATCHMAN</p> <p>32. SIGNATURE OF GROUNDKEEPER</p> <p>33. SIGNATURE OF PLANTER</p> <p>34. SIGNATURE OF FLOWER DELIVERER</p> <p>35. SIGNATURE OF CATERER</p> <p>36. SIGNATURE OF BAKER</p> <p>37. SIGNATURE OF BUTCHER</p> <p>38. SIGNATURE OF FARMER</p> <p>39. SIGNATURE OF MILLER</p> <p>40. SIGNATURE OF TANNER</p> <p>41. SIGNATURE OF WEAVER</p> <p>42. SIGNATURE OF CARPENTER</p> <p>43. SIGNATURE OF JOINER</p> <p>44. SIGNATURE OF COOPER</p> <p>45. SIGNATURE OF BLACKSMITH</p> <p>46. SIGNATURE OF SHOE MAKER</p> <p>47. SIGNATURE OF HATTER</p> <p>48. SIGNATURE OF MILLINER</p> <p>49. SIGNATURE OF DRESSMAKER</p> <p>50. SIGNATURE OF HAIR DRESSER</p> <p>51. SIGNATURE OF BEAUTICIAN</p> <p>52. SIGNATURE OF JEWELER</p> <p>53. SIGNATURE OF OPTICIAN</p> <p>54. SIGNATURE OF PHOTOGRAPHER</p> <p>55. SIGNATURE OF MUSICIAN</p> <p>56. SIGNATURE OF DANCER</p> <p>57. SIGNATURE OF ACTRESS</p> <p>58. SIGNATURE OF ACTOR</p> <p>59. SIGNATURE OF COMEDIAN</p> <p>60. SIGNATURE OF SINGER</p> <p>61. SIGNATURE OF WRITER</p> <p>62. SIGNATURE OF EDITOR</p> <p>63. SIGNATURE OF PUBLISHER</p> <p>64. SIGNATURE OF BOOKSELLER</p> <p>65. SIGNATURE OF NEWSDEALER</p> <p>66. SIGNATURE OF POSTMAN</p> <p>67. SIGNATURE OF MESSENGER</p> <p>68. SIGNATURE OF CARRIER</p> <p>69. SIGNATURE OF DELIVERY PERSON</p> <p>70. SIGNATURE OF COLLECTION AGENT</p> <p>71. SIGNATURE OF SALES PERSON</p> <p>72. SIGNATURE OF SERVICE PERSON</p> <p>73. SIGNATURE OF MAINTENANCE PERSON</p> <p>74. SIGNATURE OF CLEANING PERSON</p> <p>75. SIGNATURE OF REPAIR PERSON</p> <p>76. SIGNATURE OF INSPECTION PERSON</p> <p>77. SIGNATURE OF TESTING PERSON</p> <p>78. SIGNATURE OF MEASUREMENT PERSON</p> <p>79. SIGNATURE OF RECORDING PERSON</p> <p>80. SIGNATURE OF INDEXING PERSON</p> <p>81. SIGNATURE OF FILING PERSON</p> <p>82. SIGNATURE OF RETRIEVAL PERSON</p> <p>83. SIGNATURE OF DISTRIBUTION PERSON</p> <p>84. SIGNATURE OF ARCHIVING PERSON</p> <p>85. SIGNATURE OF PRESERVATION PERSON</p> <p>86. SIGNATURE OF RESTORATION PERSON</p> <p>87. SIGNATURE OF REPRODUCTION PERSON</p> <p>88. SIGNATURE OF CONSULTATION PERSON</p> <p>89. SIGNATURE OF RESEARCH PERSON</p> <p>90. SIGNATURE OF ANALYSIS PERSON</p> <p>91. SIGNATURE OF SYNTHESIS PERSON</p> <p>92. SIGNATURE OF EVALUATION PERSON</p> <p>93. SIGNATURE OF RECOMMENDATION PERSON</p> <p>94. SIGNATURE OF IMPLEMENTATION PERSON</p> <p>95. SIGNATURE OF MONITORING PERSON</p> <p>96. SIGNATURE OF REPORTING PERSON</p> <p>97. SIGNATURE OF COMMUNICATION PERSON</p> <p>98. SIGNATURE OF COORDINATION PERSON</p> <p>99. SIGNATURE OF MANAGEMENT PERSON</p> <p>100. SIGNATURE OF LEADERSHIP PERSON</p>	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12328

CERTIFICATE OF DEATH

12326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>3yr. 6mo. 2days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Assunta</u> Middle <u>Palleschi</u> Last <u>GIORDANO</u>		4. DATE OF DEATH Month <u>November</u> Day <u>5</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-27-82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>(Alien) Italy</u>	
13. FATHER'S NAME <u>Peppino (Giuseppe Giordano)</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Maschetti</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-8557</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Myocarditis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 3</u> , 19 <u>55</u> , to <u>November 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 5</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Springfield State Hospital</u> <u>11-5-58</u>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>Springfield State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Ilse Kamm, M. D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Nov. 8 - 1958</u>	<u>HOLY REDEEMER</u>	<u>Baltimore 6 Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Dellerhoe</u>		ADDRESS <u>322 S. High St</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kamm</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

1932

1. PLACE OF DEATH

2. COUNTY

3. CITY OR TOWN

4. STREET

5. APARTMENT

6. BUILDING

7. DISTRICT

8. ZIP CODE

9. NAME OF DECEASED

10. SEX

11. AGE

12. DATE OF BIRTH

13. PLACE OF BIRTH

14. OCCUPATION

15. CAUSE OF DEATH

16. MANNER OF DEATH

17. SIGNATURE OF DECEASED

18. SIGNATURE OF WITNESS

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF CLERK

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CORONER

24. SIGNATURE OF JURY

25. SIGNATURE OF COURT

26. SIGNATURE OF STATE

27. SIGNATURE OF NATION

28. SIGNATURE OF WORLD

29. SIGNATURE OF UNIVERSE

30. SIGNATURE OF GOD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12329

CERTIFICATE OF DEATH

Reg. Dist. No.

12327

1. PLACE OF DEATH a. COUNTY CARROLL SYKESVILLE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 3 yrs 3 mo 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGFIELD STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, 18	
3. NAME OF DECEASED (Type or print) First EDITH Middle F Last GRIMMELL		4. DATE OF DEATH Month November Day 2 Year 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-91
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 11 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone operator		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME ATWOOD S. FORMAN		14. MOTHER'S MAIDEN NAME EDITH WILSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 217-07-7651	
17. INFORMANT Katherine Eckert, 18 E. 24th St. Baltimore 18		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 420.1 DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated circulatory disturbance & cerebral arteriosclerosis & venous		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) rotic reaction	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-21-1955 , 19 55 , to 11-2- 19 58 , that I last saw the deceased alive on November 2 , 19 58 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Elizabeth Knopp M.D. Springfield State Hospital		ADDRESS (Street, city or town, state) Sykesville, Maryland	
PHYSICIAN'S NAME (Type) ELIZABETH KNOPP		DATE SIGNED 	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-5-58	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS 	
24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

CERTIFICATE OF DEATH

1968

FILE NO.

MARYLAND

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

Acute Myocardial Infarction
Coronary Arteriosclerosis

Signature of Physician

Baltimore

DATE OF SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12330

CERTIFICATE OF DEATH

Reg. Dist. No.

12328

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster #4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mailland</u> First <u>House</u> Middle <u>House</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>24</u> Day <u>1958</u> Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Allegheny Co Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harold Shearer</u>		14. MOTHER'S M maiden NAME <u>Sarah Shaw</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Harry Sippy</u> Address <u>Manchester Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (Flu)</u> <u>480X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Tuberculosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-23-58</u> , 19 <u>58</u> , to <u>11-24-58</u> , that I last saw the deceased alive on <u>11-23-58</u> , and that death occurred at <u>1205 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm C J Smeth</u> M.D.		ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md</u>	
PHYSICIAN'S NAME (Type) <u>Wm Earl Jaynette MD</u>		DATE SIGNED <u>11-24-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Westminster Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fredrich Bucher</u> ADDRESS <u>Manchester</u>		24a. REC'D BY REGISTRAR <u>59</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Kenna</u>
		DATE <u>NOV 26 '58</u>	

CERTIFICATE OF DEATH

18330

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1868		5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer	
7. MARITAL STATUS Married		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School		11. PRESENT ADDRESS Rt. 1, Box 123, Baltimore, Md.		12. DATE OF DEATH 1933	
13. CAUSE OF DEATH Heart Disease		14. PLACE OF DEATH Home		15. TIME OF DEATH 10:30 AM		16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF REGISTRAR J. H. Smith		18. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
19. PLACE OF INTERMENT Catholic Cemetery		20. DATE OF INTERMENT 1933		21. SIGNATURE OF MINISTER J. H. Smith		22. SIGNATURE OF CLERGYMAN J. H. Smith		23. SIGNATURE OF CHURCH WARDEN J. H. Smith		24. SIGNATURE OF CHURCH CLERK J. H. Smith	
25. SIGNATURE OF DECEASED J. H. Harris		26. SIGNATURE OF NEXT OF KIN J. H. Harris		27. SIGNATURE OF SURVIVOR J. H. Harris		28. SIGNATURE OF SURVIVOR J. H. Harris		29. SIGNATURE OF SURVIVOR J. H. Harris		30. SIGNATURE OF SURVIVOR J. H. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12331

CERTIFICATE OF DEATH

Reg. Dist. No.

12329

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 14 Sherwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle HARDT Last HARDT				4. DATE OF DEATH Month 11 Day 2 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/13/87	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 11 Days 2 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 2 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Butcher				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Adam Hardt				14. MOTHER'S MAIDEN NAME Catherine ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 320 01 1927		17. INFORMANT Mrs. Russell Kamps Address 14 Sherwood Dr., Jessups, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 493X DUE TO (c) 493X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.1 Chronic Alcoholism.						INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/24/58 , to 11/2/58 , that I last saw the deceased alive on 11/2/58 , and that death occurred at 4 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore 29, Md. DATE SIGNED 11/2/58 ACTUAL SIGNATURE Julian Radzykewycz M.D. PHYSICIAN'S NAME (Type) JULIAN RADZYKENYECZ MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5/58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witke Funeral Directors 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR DATE NOV 5 58		24b. REGISTRAR'S SIGNATURE Carlton S. Hume	

12332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster		c. LENGTH OF STAY IN 1b 12 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westminster			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harmon Middle E. Last Hayden			4. DATE OF DEATH Month November Day 17 Year 1958				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1887		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Hayden			14. MOTHER'S MAIDEN NAME Martha J. Green				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mary Hayden, Route #7, Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO 592x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO Chronic Nephritis (c) Hypertension Vascular DUE TO Hypertension Vascular							INTERVAL BETWEEN ONSET AND DEATH 5 days 4 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 483x Cerebro-Vascular Accident & Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Aug , 19 52 to Nov 17 , 19 58 that I last saw the deceased alive on Nov. 17 , 19 58 , and that death occurred at 5:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Taneytown, Md. DATE SIGNED 11/19/58							
ACTUAL SIGNATURE E. Aubrey Thompson				DATE SIGNED 11/19/58			
PHYSICIAN'S NAME (Type) E. A. Thompson				Taneytown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 20, 1958	22c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens		22d. LOCATION (City, town, or county) (State) Finksburg, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son				ADDRESS C.O. Fuss & Son, Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE NOV 21 '58	
				24b. REGISTRAR'S SIGNATURE Charles L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

City of _____

State of _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12331

12333

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll Maryland MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville				c. LENGTH OF STAY IN 1b Lyr. 7mo. 17days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Toivo Middle Rudolph Last Heleen				4. DATE OF DEATH Month 11 Day 9 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-17-1910	
9. AGE (In years last birthday) yrs. 48		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Emil Heleen				14. MOTHER'S MAIDEN NAME Jennie Lahti			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 022-10-9516		17. INFORMANT Address Hospital Records, Springfield State Hospital Sykesville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) CBS assoc. with other diseases of unknown or uncertain cause, with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-22-1957 , 19___, to 11-9-1958 , 19___, that I last saw the deceased alive on 11-9-1958 , 19___, and that death occurred at 8:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11-10-1958 ACTUAL SIGNATURE Walter Knopp M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Walter Knopp, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-58		22c. NAME OF CEMETERY OR CREMATORY Center Cemetery		22d. LOCATION (City, town, or county) (State) West Wareheim, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR NOV 13 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knapp			

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. HARRIS</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915-10-15</u></p>		<p>4. Age: <u>45</u></p>	
<p>5. Place of birth: <u>NEW YORK, N.Y.</u></p>		<p>6. Race: <u>White</u></p>	
<p>7. Usual residence: <u>1234 E. BALTIMORE ST., BALTIMORE, MD.</u></p>		<p>8. Date of death: <u>1960-12-10</u></p>	
<p>9. Time of death: <u>10:15 AM</u></p>		<p>10. Place of death: <u>Home</u></p>	
<p>11. Cause of death: <u>Myocardial Infarction</u></p>			
<p>12. Manner of death: <u>Natural</u></p>			
<p>13. Signature of physician: <u>[Signature]</u></p>			
<p>14. Signature of registrar: <u>[Signature]</u></p>			
<p>15. Date of registration: <u>1960-12-15</u></p>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12334
CERTIFICATE OF DEATH

12332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(Rural) Sykesville</u>				c. LENGTH OF STAY IN 1b <u>11yr.3mo.19days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Hessian</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-21-1888</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>		IF UNDER 24 HRS. Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd Jobs</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---unk---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John J. Hessian</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with disturbance of metabolism</u> <u>growth or nutrition with senile brain disease, without qualifying phrase</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>---</u> p. m. <u>---</u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August</u> 19 <u>55</u> to <u>Nov. 14</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Nov. 14</u> 19 <u>58</u> , and that death occurred at <u>7:30 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>11-17-58</u> ACTUAL SIGNATURE <u>Walter Knopp</u> M.D. <u>Springfield State Hospital</u> PHYSICIAN'S NAME (Type) <u>Walter Knopp, M.D.</u> <u>Sykesville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11-19-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth A. Hight</u>				ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 20 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hight</u>							

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100

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12335

CERTIFICATE OF DEATH

12333

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11 Y 4 M 6 D		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond 14X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Box 95		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Myrtle Middle Howard Last Ireland				4. DATE OF DEATH Month November Day 23 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/90	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY -		14. MOTHER'S MAIDEN NAME Catherine Woorell	
13. FATHER'S NAME James F. Ireland				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -			
16. SOCIAL SECURITY NO. -				17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) -				INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with mental deficiency.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour - a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7 19 55 , to November 23 19 58 , that I last saw the deceased alive on November 23 19 58 , and that death occurred at 8:06 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/23/58							
ACTUAL SIGNATURE Agustin del Campo M.D.				PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11/26/58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery, Baltimore Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell, Sykesville Md.				24a. REC'D BY REGISTRAR 11/23/58		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

12336

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 1804 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Edward		Middle Johnson		Last Johnson	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Gloucester Co., Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Johnson				14. MOTHER'S MAIDEN NAME Alice Moody			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Edward Johnson - Patient			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gangrenous pneumonia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 10, 1958 , to November 11, 1958 , that I last saw the deceased alive on November 11, 1958 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 11-11-58 ACTUAL SIGNATURE E. M. Maculans M.D. PHYSICIAN'S NAME (Type) Edgar M. Maculans, M.D. Henryton State Hospital, Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 18 1958		22c. NAME OF CEMETERY OR CREMATORY St. Charles		22d. LOCATION (City, town, or county) (State) Ann Arundel County Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Brown				ADDRESS 985 Broad Hk		24a. REC'D BY REGISTRAR DATE NOV 17 58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
16M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12335

Reg. Dist. No.

12305

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>43 UNION ST</u>				d. STREET ADDRESS <u>143 UNION ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MAMIE IRENE JONES</u>			4. DATE OF DEATH Month Day Year <u>Nov. 10 1958</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 31 - 1888</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM MILBERRY</u>			14. MOTHER'S MAIDEN NAME <u>MARTHA BRIGHTFULL</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>DOROTHY SMITH WESTMINSTER MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>443A</u> IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>Hypertension</u> (b) <u>Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>8 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart was decompensated</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1957</u> to <u>Nov. 10, 1958</u> that I last saw the deceased alive at <u>Nov 10, 1958</u> , and that death occurred at <u>6:30 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemper ave 11/10/58</u> DATE SIGNED ACTUAL SIGNATURE <u>E. Reese Wilkens</u> M.D. PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u> <u>Westminster Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT JOY</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons</u>				ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12337

CERTIFICATE OF DEATH

12336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 11mos. 27 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. NAME OF DECEASED (Type or print) First Middle Last Michael Edward Judge		4. DATE OF DEATH Month Day Year November 20 19 58		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 1302 Hillman St.													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 28, 1869		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - RETIRED		10b. KIND OF BUSINESS OR INDUSTRY - BALTO. CITY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Unknown PATRICK JUDGE		14. MOTHER'S MAIDEN NAME Unknown ANNIE MELVIN													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular 443X DUE TO heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to cerebral arteriosclerosis with psychotic reaction.												INTERVAL BETWEEN ONSET AND DEATH years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTO, MD.		(County)		(State)					
21. I certify that I attended the deceased from July 1, 1958 , to November 20 1958 , that I last saw the deceased alive on November 20, 19 58 , and that death occurred at 10:06 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/21/58 ACTUAL SIGNATURE Ellis S. Margolin M.D. PHYSICIAN'S NAME (Type) Ellis Margolin, M.D. Sykesville, Maryland															
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-25-1958		22c. NAME OF CEMETERY OR CREMATORY CATHEDRAL		22d. LOCATION (City, town, or county) BALTO, MD.		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE J. Walter Conklin		ADDRESS 5444 BELAIR RD.		24a. REC'D BY REGISTRAR NOV 25 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Knapp									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12306

CERTIFICATE OF DEATH

Reg. Dist. No.

12337

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>168 1/2 BOND ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES HOWARD KEEFER</u>				4. DATE OF DEATH Month Day Year <u>11 / 16 / 19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25 / 1886</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL COUNTY MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CALVIN KEEFER</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE B. OTTO</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-28-1057</u>		17. INFORMANT <u>SON HOWARD S. KEEFER</u> Address <u>39 W. GREEN ST. WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO <u>Chronic Myocarditis Arteriosclerosis + Bronchial Asthma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>General</u> <u>Y10</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>Nov 15, 19 58</u> to <u>Nov 16, 19 58</u> , that I last saw the deceased alive on <u>Nov 15, 19 58</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Peichen</u>				ADDRESS (Street, city or town, state) <u>Westminster Md</u> DATE SIGNED <u>11/17/58</u>			
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Saffell</u> ADDRESS <u>254 E. Main St. Westminster Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12338

CERTIFICATE OF DEATH

Reg. Dist. No.

12338

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 311 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRINGFIELD STATE Hosp.		d. STREET ADDRESS 934 Ashland Court, Baltimore 2, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ANNA Last KIRMES		4. DATE OF DEATH Month 11 Day 7 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NICHOLAS Schonberg		14. MOTHER'S MAIDEN NAME HENRIETTA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. HOSPITAL RECORDS Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URÆMIC COMA 446X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic vascular Disease of the kidneys DUE TO (c) General Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 24 hrs years 11
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-3 , 19 55 , to 11-7 , 19 58 , that I last saw the deceased alive on 11-7 , 19 58 , and that death occurred at 8:05 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Rita S. Glahn		ADDRESS (Street, city or town, state) Springfield State Hosp DATE SIGNED 11-7-58	
PHYSICIAN'S NAME (Type) RITA S. GLAHN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11/11/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE F. J. McPherson - 1300 Eastwood		24a. REC'D BY REGISTRAR NOV 10 '58 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12339

CERTIFICATE OF DEATH

Reg. Dist. No. 12339

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First Joseph Middle Knight Last Knight		4. DATE OF DEATH Month November Day 13 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR: Months 3 Days 01 Hours 4 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Shower	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sliscer Knight		14. MOTHER'S MAIDEN NAME Mary N. Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, hebephrenic type. Pulmonary tuberculosis, far advanced, active.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 27, 19 55 , to November 13, 19 58 , that I last saw the deceased alive on November 12, 19 58 , and that death occurred at 12:25 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Julian Radd, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/13/58	
PHYSICIAN'S NAME (Type) Julian Radd, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-15-58	
22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Hays		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR DATE NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1923

1923

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		35		Jan 15, 1923		St. Paul, Minn.	
Cause of death		Disease		Organ		Nature		Site	
Myocardial infarction		Coronary artery disease		Heart		Narrowing of coronary arteries		Left ventricle	
Duration of illness		Previous illness		Occupation		Education		Marital status	
2 weeks		Hypertension		Carpenter		High school		Married	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of funeral director	
J. Smith, M.D.		A. Jones		B. Doe		C. White		D. Black	
Date of certificate		Place of certificate		Signature of registrar		Signature of informant		Signature of witness	
Jan 15, 1923		St. Paul, Minn.		A. Jones		B. Doe		C. White	

1 4 M 15 1 2 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 12340 12340 Reg. Dist. No. 12340 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 11 days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14 3v01-4 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital d. STREET ADDRESS 6114 Glenoak Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ 3. NAME OF DECEASED (Type or print) First Middle Last Carl KRAUSS 4. DATE OF DEATH Month Day Year November 3, 19 58 5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH October 12, 1897 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman 10b. KIND OF BUSINESS OR INDUSTRY BALTO CITY- 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME Andrew Krauss 14. MOTHER'S MAIDEN NAME Marilyn Burry 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. - 17. INFORMANT Springfield Hospital Records Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Pulmonary tuberculosis, far advanced, active DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with psychotic reaction, plus pulmonary tuberculosis. INTERVAL BETWEEN ONSET AND DEATH Years 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from October 22, 19 58, to November 3, 19 58, that I last saw the deceased alive on November 3, 19 58, and that death occurred at 6:53 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11/4/58 ACTUAL SIGNATURE Ellis S. Margolin M.D. PHYSICIAN'S NAME (Type) Ellis S. Margolin, M.D. Springfield Hospital Sykesville, Maryland 22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 11-7-58 22c. NAME OF CEMETERY OR CREMATORY Balt Natl 22d. LOCATION (City, town, or county) (State) Balt Md 23. FUNERAL DIRECTOR'S SIGNATURE Lemard J Ruck ADDRESS 5305 Harford 24a. REC'D BY REGISTRAR DATE 24b. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

1940

REG. 214.10

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York City	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Artery Disease		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Hospital or Institution	
Jan 15, 1940		10:30 AM		1234 Main St.		J. Smith, M.D.		St. Mary's Hospital	
Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Burial Officer	
J. Doe		J. Smith		J. Doe		J. Smith		J. Doe	

Vertical text on the right margin, likely a filing or processing stamp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12341

CERTIFICATE OF DEATH

Reg. Dist. No.

12341

1. PLACE OF DEATH o. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 21 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6 d. STREET ADDRESS 8779 Philadelphia Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Frederick Middle Kreisel Last Kreisel				4. DATE OF DEATH Month 11 Day 26 Year 1958									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-6-1871		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith—Retired				10b. KIND OF BUSINESS OR INDUSTRY Blacksmith				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Kreisel						14. MOTHER'S MAIDEN NAME Unknown Hansge							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. *****		17. INFORMANT Edwin Kreisel, Son, 1129 S. Hanover St. Baltimore 30, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic rheumatic heart disease 416X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old fibrotic pulmonary tuberculosis, healed DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH years													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X CBS associated with senile brain disease, with psychotic reaction.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield State Hospital		(County) (State)			
21. I certify that I attended the deceased from 11-5-58 , 19 58 , to 11-26- , 19 58 , that I last saw the deceased alive on 11-26- , 19 58 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11-26-58													
ACTUAL SIGNATURE Agustin del Campo M.D. PHYSICIAN'S NAME (Type) Agustin del Campo, M. D.				DATE SIGNED 11-26-58 Sykesville, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov 29, 1958		22c. NAME OF CEMETERY OR CREMATORY Parkwood				22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home ADDRESS 7701 Belair Rd						24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

12342

CERTIFICATE OF DEATH

12342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle M. Last Little		4. DATE OF DEATH Month November Day 7 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Cemetery	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry S. Little		14. MOTHER'S MAIDEN NAME Sarah Englebert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-05-2073	
17. INFORMANT Mrs. David Little, Taneytown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodge Kins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 6, 1958 to Nov 7, 1958 , that I last saw the deceased alive on Nov 5, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Taneytown Md 11/7/58			
ACTUAL SIGNATURE E. Ambler Thompson, M.D.		PHYSICIAN'S NAME (Type) E. Ambler Thompson, Taneytown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/58	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or county) (State) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuas C.O. Fuas & Son, Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE Nov 10 1958	
24b. REGISTRAR'S SIGNATURE Arthur L. Fuas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED George J. Thompson		AGE 50 years		SEX Male	
DATE OF DEATH January 15, 1915		PLACE OF DEATH Home		CITY Baltimore	
CITY OF DEATH Baltimore		COUNTY Baltimore		STATE Maryland	
OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married	
BIRTH DATE January 15, 1865		BIRTH PLACE Baltimore, Maryland		PARENTS Mr. David Little, Jacobtown, Maryland	
PREVIOUS ILLNESS None		MEDICAL ATTENDANCE None		BURIAL PLACE St. Mary's Cemetery	
DATE OF BURIAL January 17, 1915		PLACE OF BURIAL St. Mary's Cemetery		CITY OF BURIAL Baltimore	
CITY OF BURIAL Baltimore		COUNTY OF BURIAL Baltimore		STATE OF BURIAL Maryland	
DECEASED'S SIGNATURE George J. Thompson		WITNESSES None		REGISTRAR'S SIGNATURE None	
DATE January 15, 1915		PLACE Baltimore		CITY Baltimore	

Item 1 Film G235 11-17-58 et

CERTIFICATE OF DEATH

12343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "At home of Niece."		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown	
d. STREET ADDRESS West Baltimore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lydia Ann Little		4. DATE OF DEATH Month Day Year November 8, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 21, 1870
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Aulthouse		14. MOTHER'S MAIDEN NAME Martha Angell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Carroll Newcomer, Taneytown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis & myocardial degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Semility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-17 , 19 57 , to 11-8 , 19 58 , that I last saw the deceased alive on 11-8 , 19 58 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Leonard L. Potter M.D. 12 W. King St. Littlestown, Pa. 11-10-58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) LEONARD L. POTTER 12 W. KING ST. LITTLESTOWN, PA			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/11/58	
22c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son, Taneytown, Maryland		ADDRESS 24a. REC'D BY REGISTRAR DATE NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

CERTIFICATE OF DEATH

DAVID

WYLAND

DAVID

West 11th Street

Little

November 3

January 1, 1900

White

WYLAND

WYLAND

WYLAND

WYLAND

WYLAND

WYLAND

WYLAND

WYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12344

CERTIFICATE OF DEATH

Reg. Dist. No. 12344

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4 mos. 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 4100 Glenmore Ave., Zone 6			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lillian Middle Elizabeth Last Lunz				4. DATE OF DEATH Month November Day 19 Year 19 58					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1912			
9. AGE (In years lost birthday) 46 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 58 Min.		IF UNDER 24 HRS. Months 4 Days 19 Hours 58 Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME John Lunz				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac hypertrophy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depressive reaction with psychosis. 491X								INTERVAL BETWEEN ONSET AND DEATH Weeks Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 15, 1958 to November 19, 1958 that I last saw the deceased alive on November 18, 1958 , and that death occurred at 2:00A. M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Agustini del Campo				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11/19/58			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.				Sykesville, Maryland					
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 11/22/58		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md			
23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Webster Funeral Home Inc				ADDRESS 6306 Belair Rd, Balto 6, Md.		24a. REC'D BY REGISTRAR DATE NOV 24 '58			
24b. REGISTRAR'S SIGNATURE Arthur L. Krand									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12345
CERTIFICATE OF DEATH

Reg. Dist. No. 12345

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr. 9 mos. 25 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City 13X-2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) First Mary Middle Rebecca Last MAKINSON		4. DATE OF DEATH Month November Day 12 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shirtmaker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Makinson		14. MOTHER'S MAIDEN NAME Agnes Isaac	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. Fracture, left humerus. 904.9		INTERVAL BETWEEN ONSET AND DEATH Years Years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **January 17, 1958** to **November 12, 1958** that I last saw the deceased alive on **November 12, 1958**, and that death occurred at **1:40 P** M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Springfield Hospital** DATE SIGNED **11/12/58**

ACTUAL SIGNATURE **Agustin del Campo** M.D. **Springfield Hospital**

PHYSICIAN'S NAME (Type) **Agustin del Campo, M.D.** **Sykesville, Maryland**

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-15-58	22c. NAME OF CEMETERY OR CREMATORY ST. JOHNS	22d. LOCATION (City, town, or county) (State) ELICOTT CITY Md.
23. FUNERAL DIRECTOR'S SIGNATURE FC [Signature]		24a. REC'D BY REGISTRAR DATE NOV 18 58	24b. REGISTRAR'S SIGNATURE Arthur S. [Signature]

ARKYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

12346

CERTIFICATE OF DEATH

12346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 248 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				d. STREET ADDRESS 2419 Baker Street			
3. NAME OF DECEASED (Type or print) First Sandy Middle McCoy Last McCoy				4. DATE OF DEATH Month November Day 29 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5-1909		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Mixer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Sandy McCoy, Sr.				14. MOTHER'S MAIDEN NAME Margaret Rupper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Sandy McCoy - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Disease 003.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old Tuberculous Pleurisy and Potts disease of DUE TO (c) Lumbar Spine (five)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from March 26, 1958 to November 29, 1958 , that I last saw the deceased alive on November 29, 1958 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. M. Maculans			ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 11-29-58		
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M.D.			Henryton State Hospital, Henryton, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 12/1/58	22c. NAME OF CEMETERY OR CREMATORY mt Auburn		22d. LOCATION (City, town, or county) Baltimore		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Strauss			ADDRESS 12302 W. North Ave Baltimore		24a. REC'D BY REGISTRAR Arthur S. Strauss		24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12347

CERTIFICATE OF DEATH

12347

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 34y.7m.6d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS -----			
3. NAME OF DECEASED (Type or print) First ANNIE Middle THERESA Last MEYERS				4. DATE OF DEATH Month November Day 29 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-28-78	
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months 3 Days 01 Hours 4		IF UNDER 24 HRS. Hours 4 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Meyers				14. MOTHER'S MAIDEN NAME Theresa Hartman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Record, Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with convulsive disorder, without qualifying phrase. Mental deficiency, undifferentiated 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 10-20-54 , 19____, to 11-29-58 , 19____, that I last saw the deceased alive on November 29 , 19 58 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-58		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight ADDRESS Sykesville, Md.				24a. REC'D BY REGISTRAR DATE DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12348

CERTIFICATE OF DEATH

Reg. Dist. No.

12348

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco			
3. NAME OF DECEASED (Type or print) First Bessie Middle Morgan Last Myerly				4. DATE OF DEATH Month November Day 16 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1876	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME S. Howard Lockard				14. MOTHER'S MAIDEN NAME Mary V. Read			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Howard H. Myerly Address Liberty St. Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Several lines) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-renal-vascular disease DUE TO (c) Senility						INTERVAL BETWEEN ONSET AND DEATH 4 days about 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	
20f. (City or town) ---				20g. (County) ---		20h. (State) ---	
21. I certify that I attended the deceased from Nov. 17 19 50 , to Nov. 14 19 58 , that I last saw the deceased alive on Nov. 15 19 58 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED Nov. 11-17-58							
ACTUAL SIGNATURE C. Levine Billingslea M.D.				PHYSICIAN'S NAME (Type) C. Levine Billingslea M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11-19-58		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove	
22d. LOCATION (City, town, or county) Sandyville, Md.				22e. (State) Maryland		22f. (County) ---	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers				ADDRESS Westminster, Maryland		24a. REC'D BY REGISTRAR DATE NOV 20 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Thoms				24c. (State) ---			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Race		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John A. Jones		Male		45		Jan 1, 1900		Baltimore, Md.		White		Roman Catholic		Married		Teacher		Heart Disease		Jan 15, 1945		Home		10:00 AM		J. A. Jones		J. B. Smith		J. C. Brown	
Name of Informant		Relationship		Address		City		State		Zip		Signature of Informant		Signature of Registrar		Signature of Witness		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist	
Mary A. Jones		Wife		1234 Main St.		Baltimore		Md.		21201		M. A. Jones		J. B. Smith		J. C. Brown		J. A. Jones		J. B. Smith		J. C. Brown		J. A. Jones		J. B. Smith		J. C. Brown		J. A. Jones	
Name of Burial Place		Date of Burial		Time of Burial		Signature of Minister		Signature of Registrar		Signature of Witness		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Pathologist		Signature of Anatomist		Signature of Surgeon		Signature of Dentist		Signature of Nurse		Signature of Pharmacist		Signature of Veterinarian	
St. Mary's Church		Jan 16, 1945		11:00 AM		J. A. Jones		J. B. Smith		J. C. Brown		J. A. Jones		J. B. Smith		J. C. Brown		J. A. Jones		J. B. Smith		J. C. Brown		J. A. Jones		J. B. Smith		J. C. Brown		J. A. Jones	

12349 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 8 Film G236 12-11-58 et
 12349
 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Airy</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural - Mt. Airy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Parrsville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN W. MYERS</u>		4. DATE OF DEATH Month Day Year <u>November 28 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Melvin Myers</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-09-7320</u>	
17. INFORMANT Address <u>Melvin Myers, Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>Several years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 1953, to <u>Nov</u> , 1958, that I last saw the deceased alive on <u>November 26</u> , 1958, and that death occurred at <u>10:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt. Airy</u> DATE SIGNED <u>Nov 28, 1958</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-1-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Simpsons Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u> ADDRESS <u>Winfield, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

12350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (Rural)</u>		c. LENGTH OF STAY IN 1b <u>57 yrs. 11 das.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>Olga</u> Middle <u>Newman</u> Last <u>Newman</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Springfield State Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Peritonitis</u> 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Perforated Gastric Ulcer</u> DUE TO (c) <u>Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, paranoid type.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>58</u> , to <u>November 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 26</u> , 19 <u>58</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rita S. Glahn</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11/26/58</u>	
PHYSICIAN'S NAME (Type) <u>Rita S. Glahn, M. D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-29-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Finner</u>		ADDRESS <u>Springfield, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12351

CERTIFICATE OF DEATH

12351

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville (Rural)				c. LENGTH OF STAY IN 1b 2 y. 7 m. 4 d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 5623 Tramore Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rose Middle Louisa Last Nicklas				4. DATE OF DEATH Month November Day 17 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? 1st. papers USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Springfield State Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Cardiac insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH 1 day years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to November 17, 19 58 , that I last saw the deceased alive on November 17, 19 58 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Agustín del Campo M.D. Springfield State Hospital				PHYSICIAN'S NAME (Type) Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 11-28-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lernard J. Ruck ADDRESS 5305 Harford				24a. REC'D BY REGISTRAR DATE NOV 19 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12352

CERTIFICATE OF DEATH

Reg. Dist. No.

12352

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2936 St. Paul St.	
3. NAME OF DECEASED (Type or print) First Samuel Middle Hunter Last Norman		4. DATE OF DEATH Month November Day 11 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 2/8/1893
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Norman		14. MOTHER'S MAIDEN NAME Ethel Suman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-09-8967	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis. Generalized arteriosclerosis.		INTERVAL BETWEEN ONSET AND DEATH Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 3, 19 58 to November 11, 19 58 , that I last saw the deceased alive on November 10, 19 58 , and that death occurred at 6:55A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 11/11/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11/13/58	London Park	Balto - 29 Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard M. ...		24a. REC'D BY REGISTRAR NOV 12 '58	
ADDRESS E - 108 W. North Ave.		24b. REGISTRAR'S SIGNATURE ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12353

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flohrville		c. LENGTH OF STAY IN 1b 3 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural--Sykesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle M. Last PARKER		4. DATE OF DEATH Month NOV. Day 7, Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-26-1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter retired		10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. William Parker, Address same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure, Atherosclerosis generalized. DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis heart disease, Carcinoma DUE TO 2 Liver. (c) 2 Liver.			INTERVAL BETWEEN ONSET AND DEATH Oct 58 to 7 Nov 58
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1956 , 19____, to 7 Nov , 19 58 , that I last saw the deceased alive on 7 Nov , 19 58 , and that death occurred at 4:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard E. Hall		ADDRESS (Street, city or town, state) Sykesville, Md	
DATE SIGNED 7 Nov 58		M.D.	
PHYSICIAN'S NAME (Type) HOWARD E. HALL			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-10-1958	22c. NAME OF CEMETERY OR CREMATORY Fairmount	22d. LOCATION (City, town, or county) (State) Libertytown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR NOV 10 58		24b. REGISTRAR'S SIGNATURE Arthur S. Francis	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12354

CERTIFICATE OF DEATH

Reg. Dist. No.

13587

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 493 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Henry Last Pittman				4. DATE OF DEATH Month November Day 30 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 47 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Rocky Mount, N. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Julius Pittman				14. MOTHER'S MAIDEN NAME Laura Lilly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT James Henry Pittman - Patient Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced bilateral pulmonary tuberculosis and Diabetes Mellitus DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 25 , 19 57 , to Nov. 30 , 19 58 , that I last saw the deceased alive on Nov. 30 , 19 58 , and that death occurred at 6:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. M. Maculans				ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 11-30-58	
PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 7-1958		22c. NAME OF CEMETERY OR CREMATORY CHRIST, M.E.		22d. LOCATION (City, town, or county) (State) Pocomoke, Worcester, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward, Main St., M.L. #235				24a. REC'D BY REGISTRAR DATE DEC 9 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hearn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12355

CERTIFICATE OF DEATH

Reg. Dist. No.

12354

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. LENGTH OF STAY IN 1b <u>75 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pleasant Valley</u>				d. STREET ADDRESS <u>Pleasant Valley</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>JACOB</u> Last <u>POWELL</u>			4. DATE OF DEATH Month <u>NOV.</u> Day <u>20</u> Year <u>1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEP. 9, 1883</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - defense work shipyard</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pleasant Valley, Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Powell</u>			14. MOTHER'S MAIDEN NAME <u>Martha Myers</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-10-2386</u>		17. INFORMANT Address <u>Miss Martha C. Powell, Westminster Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular-renal disease</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> , to <u>Nov 20, 1958</u> that I last saw the deceased alive on <u>Nov 20, 1958</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemper Ave Westminister Md</u> DATE SIGNED <u>11/21/58</u>							
ACTUAL SIGNATURE <u>Reese Wilkens</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DR E. REESE WILKENS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 24 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr., Westminster Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kincaid</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of medical examiner		19. Signature of pathologist		20. Signature of anatomist	
21. Signature of coroner		22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury		28. Signature of jury	
29. Signature of jury		30. Signature of jury		31. Signature of jury		32. Signature of jury	
33. Signature of jury		34. Signature of jury		35. Signature of jury		36. Signature of jury	
37. Signature of jury		38. Signature of jury		39. Signature of jury		40. Signature of jury	
41. Signature of jury		42. Signature of jury		43. Signature of jury		44. Signature of jury	
45. Signature of jury		46. Signature of jury		47. Signature of jury		48. Signature of jury	
49. Signature of jury		50. Signature of jury		51. Signature of jury		52. Signature of jury	
53. Signature of jury		54. Signature of jury		55. Signature of jury		56. Signature of jury	
57. Signature of jury		58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury		64. Signature of jury	
65. Signature of jury		66. Signature of jury		67. Signature of jury		68. Signature of jury	
69. Signature of jury		70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury		76. Signature of jury	
77. Signature of jury		78. Signature of jury		79. Signature of jury		80. Signature of jury	
81. Signature of jury		82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury		88. Signature of jury	
89. Signature of jury		90. Signature of jury		91. Signature of jury		92. Signature of jury	
93. Signature of jury		94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury		100. Signature of jury	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12356

CERTIFICATE OF DEATH

12355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>	
c. LENGTH OF STAY IN 1b <u>7 mo. 8 das.</u>		d. STREET ADDRESS <u>R.F.D. #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Mullen</u> Last <u>Rahn</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1889</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Mullen</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Graham</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Springfield State Hospital, Records</u>		Address <u> </u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Lobar Pneumonia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>490X</u> (b) <u>2. Multiple decubital ulcers</u> DUE TO (c) <u>3. Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Months</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Manic depressive reaction, depressed type. Incipient cerebral arterio-</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>sclerosis.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>November 26, 1958</u> , that I last saw the deceased alive on <u>November 26, 1958</u> , and that death occurred at <u>11:10 p.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rita S. Glahn</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Springfield State Hospital</u> <u>11/26/58</u>	
PHYSICIAN'S NAME (Type) <u>Rita S. Glahn, M.D.</u>		<u>Sykesville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12.1.58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Howell</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>DEC 2 '58</u>	
ADDRESS <u>Pikeville 8, Md.</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12307

CERTIFICATE OF DEATH

12356

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL, CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>9 MO.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jordan Conv. Home</u>				d. STREET ADDRESS <u>1 WARFIELDS BORG</u>			
3. NAME OF DECEASED (Type or print) <u>CARRIE ESTELLE RANOULL</u>				4. DATE OF DEATH <u>NOV. 27 1958</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 10, 1879</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>THOMAS S. JONES</u>				14. MOTHER'S MAIDEN NAME <u>ANGELINE SELLERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>ELLIS C. RANOULL, MANCHESTER Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis & Hypertension</u> DUE TO (c) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u> <u>4-10</u> <u>1956</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 1956</u> <u>Nov 27</u> , 1958, that I last saw the deceased alive on <u>Nov 24</u> , 1958, and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Glenn Speicher M.D.</u>				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>W. Glenn Speicher</u>				DATE SIGNED <u>11/28/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/30/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH</u>		22d. LOCATION (City, town, or county) (State) <u>RURAL, WESTMINSTER Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe Murre, Jr. Westminster, Md</u>				24a. REC'D BY REGISTRAR <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12357 Item 2 Film G235 11-20-58 et

CERTIFICATE OF DEATH

12357

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>2 mo 25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15.56.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State</u>				d. STREET ADDRESS <u>571 University Blvd., Green's / MONTGOMERY / HOSPITAL</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Arnold</u> Middle <u>Ray</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Oct. 25, 1887</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>14</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Farmer - Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- Retired.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>William Thomas Ray</u>			
14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXX Susan Schaeffer</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>214-03-9588</u>				17. INFORMANT Address <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S an. with cerebral arteriosclerosis with psychotic reaction</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>8/9/58</u> to <u>11/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>58</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>11-9-58</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Gertrude M. Gross, M.D.</u> <u>Springfield State Hosp. Sykesville, Md.</u>							
PHYSICIAN'S NAME (Type) <u>Gertrude M. Gross</u> <u>Springfield State Hosp. Sykesville Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-12-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Colesville Church Cem.</u>			
22d. LOCATION (City, town, or county)		(State)		<u>Montgomery County, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>							
ADDRESS <u>Bethesda, Md.</u>							
24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>							
24b. REGISTRAR'S SIGNATURE <u>C. L. L. L.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

CERTIFICATE OF DEATH

Reg. Dist. No. 12358

12308

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
c. LENGTH OF STAY IN 1b <u>40 yrs</u>				d. STREET ADDRESS <u>Plunger Apts. E. Main St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plunger Apts. E. Main St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HARRY EDWARD REESE, SR.</u>				4. DATE OF DEATH <u>Nov. 15 1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan 26, 1899</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner & Landowner - Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Reese</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Little</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>hold over</u>			
17. INFORMANT <u>Harry E. Reese, Jr. Westminster, Md.</u>				Address <u>Westminster St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>15 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>58</u> , to <u>11/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>58</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>79 W. Main St. Westminster, Md.</u> DATE SIGNED <u>11/15/58</u>							
ACTUAL SIGNATURE <u>Arthur S. Kraw</u>				PHYSICIAN'S NAME (Type) <u>S. LUTHER BARE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch</u>		22d. LOCATION (City, town, or county) (State) <u>Rural Westminster, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. E. Myers, Jr. Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>Nov 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12358

CERTIFICATE OF DEATH

Reg. Dist. No.

12359

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>Life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Central Ave.</u>				d. STREET ADDRESS <u>Central Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Wanil Gray Richardson</u>				4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1958</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 16, 1883</u>		9. AGE (In years last birthday) <u>76</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Livestock Dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cattle</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Randolph R. Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Gray</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mr. Wm. Richardson</u> Address <u>Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>20 yrs.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1935</u> , 19____, to <u>22 November, 1958</u> , that I last saw the deceased alive on <u>21 November, 1958</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr.</u>				ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>11.22.58</u>					
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>				<u>Sykesville P.O., Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>			
23. FUNERAL-DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 1 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1278

MEMORANDUM

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DEATH

DIAGNOSIS

TESTS

TREATMENT

PROGNOSIS

COMMENTS

SIGNATURE

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DEATH

DIAGNOSIS

TESTS

TREATMENT

PROGNOSIS

COMMENTS

SIGNATURE

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DEATH

DIAGNOSIS

TESTS

TREATMENT

PROGNOSIS

COMMENTS

SIGNATURE

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DEATH

DIAGNOSIS

TESTS

TREATMENT

PROGNOSIS

COMMENTS

SIGNATURE

DATE

TIME

PLACE

CAUSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12359
CERTIFICATE OF DEATH

Reg. Dist. No.

12360

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b 52 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
		f. STREET ADDRESS Main St.	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GRACE M. ROUTZAHN		4. DATE OF DEATH Month NOV. Day 9, Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles E. Wilcox		14. MOTHER'S MAIDEN NAME Mary Elizabeth Quincy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Margeret Miller, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease, Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 2 wks years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral-vascular accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 56 , to Nov 9 , 19 58 , that I last saw the deceased alive on Nov. 9 , 19 58 , and that death occurred at 4:05 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Meadors M.D.		ADDRESS (Street, city or town, state) Main Street DATE SIGNED 11/10/58	
PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D.		Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-12-1958	
22c. NAME OF CEMETERY OR CREMATORY Reformed		22d. LOCATION (City, town, or county) (State) Middletown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Md.	
24a. REC'D BY REGISTRAR NOV 13 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12361

12360

1. PLACE OF DEATH a. COUNTY <u>Barnwell</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Barnwell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Snyderburg Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN - FRANKLIN SANDRUCK</u>		4. DATE OF DEATH <u>Nov 16 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8 - 1909</u>
9. AGE (in years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Sandruck</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Ely</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-36-8285</u>	
17. INFORMANT <u>John Sandruck, Taneytown Md</u>		Address <u>Taneytown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dislocated Cervical Vertebrae</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>✓</u> DUE TO (c) <u>✓</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>✓</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3</u> - p. m. <u>11-16-58</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road 30</u>	20f. (City or town) <u>Manchester</u> (County) <u>Carroll</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		DATE SIGNED <u>11/16/58</u>	
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>	22d. LOCATION (City, town, or county) (State) <u>Barnwell CO Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin A. Tipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12361

CERTIFICATE OF DEATH

12362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 49y.6m.17d.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS -----			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MINNIE Middle SCHOEN Last SCHOEN				4. DATE OF DEATH Month November Day 29 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77		IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Schoen				14. MOTHER'S MAIDEN NAME ---			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Records, Springfield State Hospital			
17. INFORMANT Records, Springfield State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Schizophrenic reaction, hebephrenic type DUE TO (c) Schizophrenic reaction, hebephrenic type PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type INTERVAL BETWEEN ONSET AND DEATH Days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 20, 1954 , to November 29, 1958 , that I last saw the deceased alive on November 29, 1958 , and that death occurred at 3:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Sykesville, Md. ADDRESS Sykesville, Maryland 24a. REC'D BY REGISTRAR DATE DEC 5 '58 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12362

CERTIFICATE OF DEATH

12363

Reg. Dist. No.

1. PLACE OF DEATH— a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 37yrs. 1mo. 5days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital.		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First Prince Albert Middle Shrout Last Shrout		4. DATE OF DEATH Month November Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1885
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Tasker		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 to November 8, 1958 that I last saw the deceased alive on November 8, 1958 and that death occurred at 2:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 11/9/58			
ACTUAL SIGNATURE Agustin del Campo M.D.		DATE SIGNED 11/9/58	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) L		22b. DATE THEREOF 11-10-58	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24a. REC'D BY REGISTRAR NOV 13 '58	
ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Newell	

12363

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION George Street				d. STREET ADDRESS George Street			
3. NAME OF DECEASED (Type or print) First William Middle Francis Last Simpson				4. DATE OF DEATH Month November Day 22 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1878		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Simpson				14. MOTHER'S MAIDEN NAME Susan Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mellie Simpson Address Taneytown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 mos 2 years 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Sept. 19, 1958 to 11/24/58 , that I last saw the deceased alive on 11/21 , 19 58 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. S. McVaugh				ADDRESS (Street, city or town, state) 49 Endicott St. Taneytown, Md.		DATE SIGNED 11/24/58	
PHYSICIAN'S NAME (Type) R. S. McVaugh							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 24, 1958	22c. NAME OF CEMETERY OR CREMATORY United Church of Christ Cemetery, Taneytown, Maryland		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss C. O. Fuss & Son				ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE NOV 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur J. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1948 NOV 20 AM 11:10
FAXIN ROOM

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Name of Deceased		Date of Birth		Sex	
John Doe		1920-01-01		Male	
Residence		Occupation		Cause of Death	
123 Main St		Teacher		Heart Disease	
City		County		Manner of Death	
Baltimore		Anne Arundel		Natural	
Date of Death		Time of Death		Place of Death	
1948-11-15		10:30 AM		Home	
Physician		Coroner		Registrar	
Dr. Smith		Mr. Jones		Mr. Brown	
Signature		Signature		Signature	
Date		Time		Place	
1948-11-15		10:30 AM		Home	

12364

CERTIFICATE OF DEATH

Reg. Dist. No. 12365

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01.4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>+8 W. Preston Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Meadow View Convalescent Home</u>				d. STREET ADDRESS <u>18 W. Preston St</u>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>PRISCILLA</u> Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1 1874</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>John P. Sley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Stansbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216734-7109</u>		17. INFORMANT <u>Mrs Ralph Royer</u> Address <u>Westminster Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V. disease</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 11</u> , 19 <u>58</u> , to <u>Nov 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>58</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.				ADDRESS (Street, city or town, state) <u>105 E. Main St</u> DATE SIGNED <u>11/1/58</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>				<u>Westminster Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Street, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kears</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12365 Items 8,9 Film 6237 12-29-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

12366

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3mos. 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3706 Nortonia Road, Zone 16	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Lee Harrell Timberlake		4. DATE OF DEATH Month Day Year November 15, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 6, 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Harrell		14. MOTHER'S MAIDEN NAME Nancy Graves	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction. Bronchopneumonia.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 491X	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Springfield, Maryland	
21. I certify that I attended the deceased from July 28, 1958 , to November 15, 1958 , that I last saw the deceased alive on November 15, 1958 , and that death occurred at 9:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Irene L. Hitchman		DATE SIGNED 11/15/58	
PHYSICIAN'S NAME (Type) Irene L. Hitchman, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 11-17-58	
22c. NAME OF CEMETERY OR CREMATORY HILL CREST		22d. LOCATION (City, town, or county) (State) LOUISA. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Dabrowski: 1001 Dunsalk Ave.		24a. REC'D BY REGISTRAR NOV 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John W. Smith		Male		45		Jan. 15, 1880		New York, N.Y.	
Residence		Occupation		Cause of Death		Duration of Illness		Place of Death	
123 Main St., Baltimore, Md.		Carpenter		Heart Disease		10 Days		Home	
Physician		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death	
Dr. J. H. Jones		Natural		[Signature]		[Signature]		Jan. 20, 1925	
Burial Place		Funeral Home		Name of Undertaker		Name of Minister		Name of Church	
Greenwood Cemetery		[Name]		[Name]		[Name]		[Name]	
Name of Informant		Relationship		Signature of Informant		Signature of Registrar		Date of Report	
[Name]		[Relationship]		[Signature]		[Signature]		Jan. 22, 1925	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12366

CERTIFICATE OF DEATH

12367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster		c. LENGTH OF STAY IN 1b 37 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural--Westminster	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle F. Last WILL		4. DATE OF DEATH Month NOV. Day 27 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Will		14. MOTHER'S MAIDEN NAME Fredericka Hintzman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 219-36-0185	
17. INFORMANT Mrs. Renie Will, same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arterio sclerosis General & Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. myocardial degeneration DUE TO myocardial degeneration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day several yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 3 , 19 58 , to Nov 27 , 19 58 , that I last saw the deceased alive on Nov 26 , 19 58 , and that death occurred at 12:05 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Glenn Speicher M.D.		ADDRESS (Street, city or town, state) Westminster Md DATE SIGNED 11/28/58	
PHYSICIAN'S NAME (Type) W. GLENN SPEICHER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-30-1958	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DEC 1 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. House	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		65		JAN 15 1885	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MD		FARMER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE	
DEC 18 1945		BALTIMORE, MD		10:30 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
DEC 18 1945		DEC 18 1945		DEC 18 1945		DEC 18 1945	
NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF CHURCH	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
DEC 18 1945		DEC 18 1945		DEC 18 1945		DEC 18 1945	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12367

CERTIFICATE OF DEATH

12368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Rural, Westminster, Md</u>	
c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		d. STREET ADDRESS <u>Westminster, RD #4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster Md, ROTH</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHERINE AUGUSTA WITTE</u>		4. DATE OF DEATH Month Day Year <u>NOV 14 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1880</u> 78 yrs.
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JORDAN</u>		14. MOTHER'S MAIDEN NAME <u>STROUT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Emma Korman, Westminster Md</u>		Address <u>RD #4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 16, 1957</u> , to <u>NOV 14, 1958</u> , that I last saw the deceased alive on <u>NOV 13, 1958</u> , and that death occurred at <u>3:30 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u>		ADDRESS (Street, city or town, state) <u>MANCHESTER, MD</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>		DATE SIGNED <u>11-14-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 16, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Seaside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westminster Md, RD #4</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. E. Myers, Jr., Westminster, Md.</u>		24. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>	
ADDRESS <u>Westminster, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filled with page 3. It will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12368 STATE DEPARTMENT OF HEALTH—BALTIMORE, 1812369
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Medhanicsville 18 X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Woodland Last Woodland		4. DATE OF DEATH Month November Day 18 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? ? 1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Oakville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Gray		14. MOTHER'S MAIDEN NAME Rebecca Smothers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Bernice Wood - 1627 N. Bentalou Street		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and heart failure DUE TO (c) Far advanced pulmonary tuberculosis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24 , 19 58 , to Nov. 18 , 19 58 , that I last saw the deceased alive on Nov. 18 , 19 58 , and that death occurred at 11:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 11-18-58 ACTUAL SIGNATURE E. M. Maculans M.D. PHYSICIAN'S NAME (Type) E. M. Maculans, M. D., Henryton State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/22/58	22c. NAME OF CEMETERY OR CREMATORY Galliee Cemetery	22d. LOCATION (City, town, or county) (State) Oakville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ROBINSON FUNERAL HOME LEONARDTOWN MD		24a. REC'D BY REGISTRAR NOV 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, or in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

12369

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 3yrs. 8mos. 12days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 2924 Miles Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Worick		4. DATE OF DEATH Month November Day 14 , Year 1958				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876- Feb. 10,	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown Joseph L. Booze		14. MOTHER'S MAIDEN NAME Unknown Mary Elizabeth Hoffman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. 902.7 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition with senile brain disease. Fracture, intertrochanteric, right femur.						INTERVAL BETWEEN ONSET AND DEATH Years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell out of bed.				
20c. TIME OF INJURY Month, Day, Year 8:00 a.m. 11/5/58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Maryland	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/15/58		
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. J. Tickner & Sons - Balto 17th			24a. RECEIVED BY REGISTRAR NOV 17 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12370

CERTIFICATE OF DEATH

12371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll Maryland <small>MARYLAND</small>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3V01-4		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Sykesville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City, Maryland Zone 31		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph Middle ----- Last Yacola			4. DATE OF DEATH Month 11 Day 7 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-86		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vendor		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Unknown ✓
13. FATHER'S NAME ---			14. MOTHER'S MAIDEN NAME ---		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	17. INFORMANT Record-Springfield State Hospital, Sykesville, Md.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.				INTERVAL BETWEEN ONSET AND DEATH more than 10 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. CBS assoc. with disturbance of metabolish, growth, nutrition, with senile brain disease, with psychotic reaction. Fecal impaction.					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from July 22 , 19 57 , to Nov. 7 , 19 58 , that I last saw the deceased alive on Nov. 6 , 19 58 , and that death occurred at 4:03 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Walter Knopp		ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 11-7-58	
PHYSICIAN'S NAME (Type) Walter Knopp, M.D.		ADDRESS Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
22d. LOCATION (City, town, or county) Balt. Md.		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Grot #322		ADDRESS 4322 S. High Street		24a. REC'D BY REGISTRAR NOV 13 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 & 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

IN THE

STATE OF

NEW YORK

COUNTY OF

NEW YORK

CITY OF

NEW YORK

DATE OF DEATH

DECEASED

RESIDENT

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12371

CERTIFICATE OF DEATH

Reg. Dist. No.

12305

1. PLACE OF DEATH a. COUNTY Carroll County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 15 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (22) d. STREET ADDRESS 810 Mildred Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) -Zippler Leo		First Middle Last Leonard Zippler		4. DATE OF DEATH Month Day Year November 15, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1888		9. AGE (In years last birthday) yrs. 70		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Kentucky			
13. FATHER'S NAME Adam Zippler			14. MOTHER'S MAIDEN NAME Mary ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW L 213-07-3933		17. INFORMANT Mrs. Ellen Spahn 810 Mildred Ave. 22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C.B.S. due to cerebral arteriosclerosis bronchopneumonia DUE TO (c) 420.0 491X				INTERVAL BETWEEN ONSET AND DEATH years. years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to cerebral arteriosclerosis bronchopneumonia 491X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 11-16-58							
ACTUAL SIGNATURE Agustin del Campo		M.D. Agustin del Campo. M.D.		Sykesville, Maryland.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Nov. 20, 58		22c. NAME OF CEMETERY OR CREMATORY Balto. National			
22d. LOCATION (City, town, or county) Frederick Road Md. Catonsville		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22, Md.			24a. REC'D BY REGISTRAR Nov 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. House		

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. RELIGION Methodist		10. EDUCATION High School	
11. DECEASED'S ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		12. DECEASED'S PHONE 2-1234		13. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		14. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		15. DECEASED'S FATHER'S NAME John Smith	
16. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		17. DECEASED'S PHONE 2-1234		18. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		19. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		20. DECEASED'S FATHER'S NAME John Smith	
21. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		22. DECEASED'S PHONE 2-1234		23. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		24. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		25. DECEASED'S FATHER'S NAME John Smith	
26. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		27. DECEASED'S PHONE 2-1234		28. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		29. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		30. DECEASED'S FATHER'S NAME John Smith	
31. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		32. DECEASED'S PHONE 2-1234		33. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		34. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		35. DECEASED'S FATHER'S NAME John Smith	
36. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		37. DECEASED'S PHONE 2-1234		38. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		39. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		40. DECEASED'S FATHER'S NAME John Smith	
41. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		42. DECEASED'S PHONE 2-1234		43. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		44. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		45. DECEASED'S FATHER'S NAME John Smith	
46. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		47. DECEASED'S PHONE 2-1234		48. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		49. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		50. DECEASED'S FATHER'S NAME John Smith	
51. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		52. DECEASED'S PHONE 2-1234		53. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		54. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		55. DECEASED'S FATHER'S NAME John Smith	
56. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		57. DECEASED'S PHONE 2-1234		58. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		59. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		60. DECEASED'S FATHER'S NAME John Smith	
61. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		62. DECEASED'S PHONE 2-1234		63. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		64. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		65. DECEASED'S FATHER'S NAME John Smith	
66. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		67. DECEASED'S PHONE 2-1234		68. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		69. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		70. DECEASED'S FATHER'S NAME John Smith	
71. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		72. DECEASED'S PHONE 2-1234		73. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		74. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		75. DECEASED'S FATHER'S NAME John Smith	
76. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		77. DECEASED'S PHONE 2-1234		78. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		79. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		80. DECEASED'S FATHER'S NAME John Smith	
81. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		82. DECEASED'S PHONE 2-1234		83. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		84. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		85. DECEASED'S FATHER'S NAME John Smith	
86. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		87. DECEASED'S PHONE 2-1234		88. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		89. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		90. DECEASED'S FATHER'S NAME John Smith	
91. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		92. DECEASED'S PHONE 2-1234		93. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		94. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		95. DECEASED'S FATHER'S NAME John Smith	
96. DECEASED'S PRESENT ADDRESS 2814 1/2 North 1st St., Memphis, Tenn.		97. DECEASED'S PHONE 2-1234		98. DECEASED'S SOCIAL SECURITY NUMBER 44-123456789		99. DECEASED'S MOTHER'S MAIDEN NAME Mary Smith		100. DECEASED'S FATHER'S NAME John Smith	